**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
HIGH POINT PHARMACY

**Respondent Name**
TWIN CITY FIRE INSURANCE COMPANY

**MFDR Tracking Number**
M4-06-2046-01

**Carrier's Austin Representative Box**
Box Number 47

**MFDR Date Received**
November 17, 2005

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "These charges are not included in any other billed procedure on the same date. All items billed are individual items needed for the patient's home use for after surgery care and were provided by the pharmacy and not the physician who performed the surgery. As the billed items are individual separate items not related to any other billed procedure, payment should be rendered."

**Amount in Dispute:** $346.24

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The insurance carrier did not submit a response for consideration in this review.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 25, 2005 | Medical Supplies | $346.24 | $281.28 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX. INCLUDED IN GLOBAL REIMBURSEMENT. REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROC BILLED.

**Findings**

1. The disputed services are medical supplies and durable medical equipment dispensed by a pharmacy for use by the injured employee at home. The insurance carrier denied disputed services with reason code 97 – "PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX. INCLUDED IN GLOBAL REIMBURSEMENT. REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROC BILLED." Per 28 Texas Administrative Code §134.202(b), " For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." The requestor submitted documentation to support that, in accordance with Medicare payment policies in effect at the time of service, "If dressing changes are sent home with the patient, claims for these dressings may be submitted . . ." Review of the submitted documentation finds that the medical bills support place of service code 12, indicating the injured employee's home. The respondent did not explain or submit documentation to support the insurance carrier's denial reasons for any of the disputed items. The insurance carrier's denial reasons are not supported. The disputed items will therefore be reviewed for reimbursement according to applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c)(2), which requires that to determine the maximum allowable reimbursements (MARs) for professional services, system participants shall apply the Medicare payment policies with the following minimal modifications: "for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." Reimbursement is calculated as follows:
   - Procedure code A4452 requires an additional modifier to be eligible for payment. Per the documentation submitted by the requestor, Medicare payment policies require that "Claims for tape (A4450 and 4452) which are billed without an AW modifier (see Coding Guidelines section) or another modifier indicating coverage under a different policy will be denied as noncovered." Review of the submitted medical bill finds that the requestor did not bill with a required modifier. Reimbursement cannot be recommended.
   - Procedure code A6255 is listed in the Medicare DMEPOS fee schedule effective for May of 2005 for Texas at a rate of $3.03 per unit. This amount multiplied by 14 units is $42.42. This amount multiplied by 125% results in a MAR of $53.03. This amount is recommended.
   - Procedure code A6402 is found on the DMEPOS fee schedule effective for May of 2005 for Texas at a rate of $0.12 per unit. This amount multiplied by 10 units is $1.20. This amount multiplied by 125% results in a MAR of $1.50. This amount is recommended.
   - Procedure code E0164 is found on the DMEPOS fee schedule effective for May of 2005 for Texas at a rate of $181.40. This amount multiplied by 125% results in a MAR of $226.75. This amount is recommended.
3. Additionally, Procedure codes A6205 and E1399 represent supplies and durable medical equipment for which neither CMS nor the Division had established a relative value or payment amount at the time of service. Per 28 Texas Administrative Code §134.202(c)(6), "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." No documentation was found to support that the insurance carrier has assigned a relative value or payment amount for these disputed items. The Division concludes that the insurance carrier has not met the requirements of §134.202(c)(6). Consequently, reimbursement is determined according to the provisions of 28 Texas Administrative Code §134.1, regarding use of the fee guidelines.
4. 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated for procedure codes A6205 and E1399.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement for procedure codes A6205 and E1399 is not supported. The requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

For the reasons stated above, the requestor has established that additional reimbursement is due. As a result, the amount ordered is $281.28.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $281.28 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Grayson Richardson | April 17, 2014 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.